Pediatric Ophthalmic Consultants
PEDIATRIC OPHTHALMOLOGY & STRABISMUS WWW.PEDSEYE.COM

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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth:**_____
Last First

Home Address:_____
Home Telephone:_____

Person or entity requesting the information and authorized to make the requested use or disclosure: _____

SPECIFY INFORMATION TO BE DISCLOSED: _____
_____
_____
_____

RECIPIENT OF THE INFORMATION: _____
ADDRESS OF RECIPIENT:_____
_____
_____
_____

TERM: This Authorization will remain in effect from the date of this Authorization until the Practice fulfills the request.

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that this Authorization will remain in effect until the practice fulfills my request.

I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____ _____
Signature of authorized or Personal Representative | Description of Authority | Date

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